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United Nations Educational Scientific and Cultural Organization

UNESCO Chair in Bioethics University of Haifa

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Contents

Editorial

Medical Education and the Ethics of Caring

Participation of trainees in patient care is an integral part of medical education. Although educating doctors is critical to society, an ethical dilemma results from the fact that patients may not benefit from doctors in training and medical students participating in their care, and may even be harmed by it. The current system of medical education, in which doctors in training and medical students participate in patient care, may expose patients to physical, psychological and economic risk, and at times without their full informed consent.

Complexity of caring for patients, difficult decisions that new technologies demand, high visibility issues like the completion of the human genome project, cloning, patenting of human tissue products and transplants are influencing medical education. This prepares future doctors to deal with the challenges that arise as a result of these newfound dilemmas. The fundamental thread that still holds all the changes and advances that is associated with medical training and medical practice is caring. While philosophers have discussed the ethics of caring[1], this subject has received little attention in medical ethics and medical education. Caring guides the doctor to continually remain the advocate of the patient and maintain the therapeutic relationship. These are important when dealing and resolving ethical dilemmas.

The principles of autonomy, beneficence, non-maleficence and justice are familiar to most medical students, who have sat in a class on medical ethics. The craft of solving ethical dilemmas by judging the weights of these four principles which often might lie in opposition to each other is generally taught. From history, evidence of bias affect applies, as to which principle trumps the others. A pertinent example of this would be beneficence; the long held principle of paternalistic medicine was replaced by autonomy. This was with the principle of patient's self-determination becoming of paramount importance. With economics, currently influencing health care access, it is likely that justice will be the principle that will take precedence.

The ethics of caring which has received focus in and outside the medical world can offer an alternative to enhancing the application of other principles and appears to be well suited to the medical environment[2]. The importance of caring as an ethical orientation has been less emphasized in medical ethics, possibly because it is obvious, that caring underlies ethical behaviour. There is evidence that medical students of both sexes naturally approach the ethical aspects of their relationship with patients within the frame work of caring[3]. In a study where medical students were given an open-ended assignment to describe an important experience with a patient, it was found that medical students rarely provide formal reasoning based on the ethical principles but almost always wrote about empathy and compassion[4].

While this experience appears to have been replicated[5], it seems to be unexplored by teachers who are involved in medical education. Thus, there is a need to consider ways in which the ethics of caring can be integrated into medical education.

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Philosophy and Ethics of Caring

Ethics of caring emphasizes moral decisions and face to face relationships. The doctors' responsibility for individual patients is grounded in the ethics of caring. The doctor-patient relationship, the therapeutic alliance and ensuring communication become the initiation for all ethical discussions. The ethics of caring assumes that connection to others is central to being human and relationships give meaning to our existence[5]. Integral to this connection is the meeting of needs of significant others, which is more than being simply fair. It can be construed that this ethics, is based on the desire to be receptive to and responsible for others in order to be a caring person. Though natural impulse to care comes from compassion and human love, true caring also incorporates reasoning, and thus cannot be reduced to problem solving. Instead of striving for impartiality in moral judgments, the ethics of caring acknowledges the importance of partiality, the special bonds and responsibilities that structure relationships.

Philosophers consider caring a moral orientation. Moral orientation results from moral reasoning, moral sensitivity, moral motivation and moral character. Moral sensitivity is the ability to recognize a moral problem when one may exist. Moral motivation, is the degree to which one might prioritize moral values over other values, Moral character is the courage, persistence and skill in implementing moral behaviour[6]. Caring incorporates attributes such as attentiveness, patience, honesty, respect, compassion and sensitivity to all aspects of moral behaviour.

A caring doctor in clinical practice demonstrates two important attributes, receptivity and responsibility. A doctor who is responsive listens to patients with empathy and compassion. A responsible doctor then transforms these feelings from the receptivity to action, which leads to meeting the patient's specific requirements.

Majority of the students enter medical school already receptive, with intense empathy for patients[7]. The students then learn to translate this innate empathy into action by taking responsibility for their patient. Thus one can appreciate the extent to which the ethics of caring, underlies and permeates medical education. This fact might not be aware to many medical students that they are training within this moral orientation. Thus understanding the ethics of caring, will benefit medical students and indeed educators. One can well appreciate, that while caring will guide the medical student's action~~s~~, it also facilitates and supports the application to patient care, the other ethical principles of beneficence, non-maleficence, autonomy and justice.

Medical Education and Ethics of caring

Medical training incorporates medical ethics as part of the curriculum. This must include the important area of ethics of caring, as it applies to the calling that the medical trainees have chosen to pursue. Three areas are required to be incorporated in medical ethics training in medical education, that relates to the important area of ethics of caring. These are 1. Inclusion of exercises that foster receptivity in students which are feelings of empathy and compassion for patients 2. Need to empower responsibility that enables, the translation of receptiveness associated with empathy and compassion into action that is reflected in responsibility for their patient and their specific requirements. 3. ~~F~~ostering a teaching environment for medical students that is conducive for caring, values and modelling the attributes of attentiveness, honesty, patience, respect, compassion, trustworthiness and sensitivity to all aspects of moral behaviour[8].

Fostering empathy and compassion for patients – Being receptive

There is evidence from studies that medical students' receptivity to their patients was more intense than what people generally develop in ordinary day to day encounters[4]. This might follow from the understanding that medical students arrive at the wards idealistic. Being inherently trusted by patients as they are future doctors and they often have time to listen to patients who are ill and dependent. This can lead to patients sharing of their most intimate thoughts and feelings. Medical students are naturally receptive in the beginning of their training[8]. Observations confirm that those doctors loose this intense receptivity to patients as the training progresses [9, 10]. The implications from this are that the medical training might fail to maintain the observed receptivity of students at the start of their training. Studies suggest that young doctors might suppress feelings and put aside values, in order to get on with training and work[11]. This phenomena of suppression of empathy, albeit temporarily, to get on with training requirements, prevents moral development and can even erode existing moral values[12, 13]. The medical student's assimilation into a ward culture that does not value empathy, in addition to the suppression, has the potential to harm the students' moral sensitivity, moral commitment and moral character which are aspects of their ability to care[14]. This can influence their ability for ethical reasoning about ethical issues.

Some success in maintaining medical student's natural receptivity throughout training has been achieved by providing medical students abundant opportunities to reflect on the meaning and purpose of their work. This is best achieved in small group activity, with carefully selected clinical faculty that facilitates the exercise. This small group exercise offers opportunities for students and faculty to share feelings and support each other[15, 16]. Reflection in small groups along with the intense learning on the ward, can balance the intense medical education process for students in a way that offers the maintenance of their caring orientation. Reflection can assist these students to integrate their natural empathy for patients into action[17]. Thus medical students should not only reflect on their values but in addition learn how to put these values into practice. These can be achieved by the combination of teaching of medical ethics and learning patient-doctor communication skills. There is good data supporting the effectiveness of these exercises[18, 19].

Putting the ethics of caring into action- Taking responsibility

Taking responsibility is the way in which caring is put into action. Medical students must be taught how to translate receptivity into responsibility. Taking responsibility, within the context of ethics of caring translates to caring for their patient and their specific requirements, despite the presence of various obstacles, whether institutional or personal. Dealing with these obstacles in the context of caring, centres on expressing empathetic understanding and attempting to build rapport by getting to know patients better. The ethics of caring places high value on maintaining the relationship, which would begin by always seeking to understand the patient's view point and getting to know the patient better. These efforts on maintaining a therapeutic relationship, would allow negotiated solutions, when obstacles do present. This then would provide the best care under the circumstances, as part of taking responsibility and translating care into action. If obstacles to action or taking responsibility arise, the potential of conflict and avoiding irresolvable conflict between student, doctor and the patient is avoided by opening discussions to a larger number of possible solutions.

The framework of caring has deeper ethical implications as it facilitates a deeper integration of ethical principles with one's motives, implementation and actions. An example of good care will require that a doctor not use the application of respect for autonomy, to get rid of a troublesome patient, who prematurely wants to sign out against medical advice. In this, the ethics of caring can temper the application of the principal of autonomy by the doctor seeking a full and deep understanding of why this patient chooses to refuse treatment. This is also done with sensitivity, attentiveness, honesty and with respect for the patient. This translates to a caring doctor, being respectful always and being aware that the patient is a vulnerable person, with less knowledge and is often dependent on their health care providers.

The required actions grounded in caring can differ from those based only on ethical principals in that caring orientation mandates that doctors honestly attempt to identify their vulnerability such as frustration, anger, counter transference, prejudice and even exhaustion that can impair their ability to care for patients. Caring requires not only being receptive to others and seeking their views but also being fully aware of one's fallibilities.

Part of the education exercise is in empowering responsibility, that enables, the translation of receptiveness associated with empathy and compassion into action. Use of role play as a regular educational exercise, is found to be useful. The students could be asked to role play a physician facing obstacles in his or her endeavours of taking responsibility for this patient and his or her specific requirements. Students are asked to talk to the patient about the identified obstacles and the consequences. This can be followed by a case discussion. From the ensuing deliberation the role-play might be redirected more productively in several ways that might bring further light on the aspect of taking responsibility as part of the ethics of caring.

Fostering a caring teaching environment that enables modelling ethics for medical students

Ideal caring atmosphere for patients extend to caring for students, residents, peers and yourselves. There is evidence that harsh treatment of care givers is unlikely to co-exist with warmth and support for patients[17]. Trainees and residents not receiving support, and being left to manage their own decisions can send a message to juniors that suggest, they are to be tough, stand alone and not expect to be cared. Teaching future doctors in an environment where caring is undervalued, might raise another ethical question. Are the care givers being asked for too much self-sacrifice? Doctors in addition to caring for patients must also know to care for themselves. Trainees and doctors, who are willing to suppress their own needs, can contribute to fostering an environment in which caring is made secondary to the many other concerns. Thus from the observations, it has been found that the care givers in trainees and doctors, should be protected from too much self-sacrifice, that might often be called for, in order that reception and responsibility in caring will be maintained.

Conclusion

Observing human behaviour and in particular how humans provide care for each other, leads to the understanding of caring philosophy. This might be observed in hospital settings, where one might observe caregivers applying the philosophy of caring in practice, even in difficult and challenging circumstances. For patients who might be dependent on their doctors, the attitudes and attributes with which the doctor delivers care, such as attentiveness, kindness and compassion, often may be as therapeutically important, as the curative treatments. Finally, the ethics of caring is a moral action that benefits patients and can be as beneficial in the application of the principles of beneficence and respecting autonomy.

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Emphasis on socio-cultural diversity of Asia Pacific region in teaching Bioethics in the medical curriculum

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AsiaPacific region

The AsiaPacific region is a very widely stretched geographical region in the world with having many cultures, religions, languages. The region has a variety of climate conditions and multiple socio-political and economic activities. The area extends from Mongolia in the north to New Zealand in the south, and from Central Asia and the Islamic Republic of Iran in the west to Kiribati in the east. AsiaPacific is the part of the world in or near the Western Pacific Ocean. The region varies in size depending on the context, but it typically includes most of East Asia, South Asia, Southeast Asia, and Oceania. [1]

On the whole, there appears to be no clear cut definition of "Asia Pacific" and the regions included change as per the context. Though imprecise, the term has become popular since the late 1980s in commerce, finance and politics.

Many countries located within Asia are not part of the Asia Pacific region, such as Afghanistan and Iraq. Similarly, many countries that are located within, or which share a border with, the Pacific Ocean (Pacific-Rim countries) are not considered part of the Asia Pacific region.[2]

Characteristics of the Asia Pacific region

As defined by the scope of the Ecoasia Project[3], the Asia Pacific region is of vast proportions with immense physical expanse, the region also presents a great historical, cultural, and ethnic diversity as well as a variety of stages of political evolution and economic development. The characteristics of the region are described here in terms of natural and environmental, economic, and cultural aspects. On the other hand, the social situation is described in terms of the roles of central and local governments, as well as the private sector and non-governmental organizations (NGOs) which are increasingly playing and are expected to play in the future.[3]

Following the above we are to understand that what is there in the society which medical practitioner to accept and do their profession more effectively and make fruitful to the society. The culture can be looked as a ‘composition’ of values, beliefs, norms, rationalizations, symbols, ideologies – that is, mental products. Another way, culture can be referred as ‘total way of life’ of a people, their interpersonal relations as well as their attitude. In one word one can say, culture is viable combination of social relations and cultural bias – a way of life [4].

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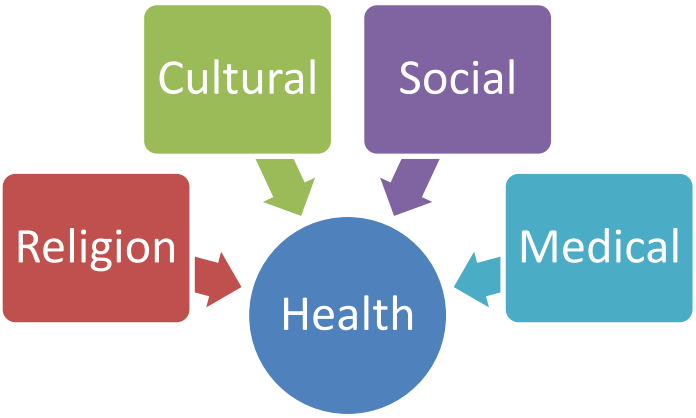
We should accept that 'culture' makes the 'conduct' of a person and therefore for a society which grows over a long time by activities, rituals they follow which again inter twined from 'external' and 'internal' behavioural factors.[5]

One of the important things about Asia Pacific is its diversity, the multitude of cultures, languages and physical landscapes, mentioned above. 'As an economist and property researcher, what's equally fascinating is the different stages of economic and property market development across the region' Dr. Jane Murray[6].

Further, as commented by Murray[6] the rapidly emerging economies of the region are seeing dramatic changes in urbanization, wealth and property markets. China, India and Indonesia are in the spotlight as they rapidly rise up the ranks in terms of economic influence and transformation of their urban environments. Thus changes the society and later the sociology and gradually the culture of a region. There are changes beliefs, in interpersonal relations and ways of life, so is case of AsiaPacific region.

Influence of Culture on health beliefs



Every individual constructs the meaning of their experience of health from within their cultural background. There are certain beliefs on etiology, cure and treatment of some illness based on culture. A patient's presentation of illness is influenced by culture. The social group in which we live influences our interpretation of the meaning of our experience of health and illness and affects our understanding of what symptoms are significant. The medical professionals everywhere are surrounded by diverse cultures with natural traditions. The doctor needs to understand how the cultural background of the patient influences the health issues[7].

Western industrialized societies such as the United States look upon disease as a result of natural scientific phenomena, advocate medical treatments using sophisticated technology to diagnose and treat disease. Some societies believe that illness is the result of supernatural phenomena and promote prayer or other spiritual interventions that counter the presumed powerful forces. Cultural issues play a major role in patient compliance[8].

Medical and paramedical professionals should be aware of important and different cultural beliefs among Asians and Pacific Islanders. The extended family has a significant influence, and the oldest

male in the family is often the decision maker and spokesperson. Maintaining harmony is an important value; therefore, there is a strong emphasis on avoiding conflict and direct confrontation. Among Chinese patients, the behaviour of the individual reflects on the family, mental illness or any behaviour that indicates lack of self-control may produce shame and guilt. Therefore, Chinese patients may be reluctant to discuss symptoms of mental illness or depression.

Indians and Pakistanis are reluctant to accept a diagnosis of severe emotional illness or mental retardation as it severely reduces the chances of other members of the family getting married. In Vietnamese culture, mystical beliefs explain physical and mental illness. Health is viewed as the result of a harmonious balance between the poles of hot and cold that govern bodily functions. Vietnamese people don't readily accept Western mental health counselling and interventions, particularly when self-disclosure is expected. However, it is possible to accept assistance if trust has been gained.

So, socio-cultural and religion has a 'say' over 'health' behaviour and therefore medical fraternity has to consider these factors while they are practising inside a society or in society of a multicultural diversity.

Medical Training in Asian Countries:

The 1988 WHO declaration states "...the aim of medical education is to produce doctors who will promote the health of all people, and that aim is not being realized in many places, despite the enormous progress that has been made during this century in the biomedical sciences. The individual patient should be able to expect a doctor as an attentive listener, a careful observer, a sensitive communicator, and an effective clinician; but it is not enough to treat only some of the sick".[9]

The standard medical curriculum in most of the countries in the Asia Pacific region consists of preclinical and clinical phases wherein basic sciences like Anatomy, Physiology, Biochemistry, Pharmacology, Pathology, Microbiology etc. are taught as subjects. During clinical phase, the students acquire knowledge and experience of diagnosis and treatment of various diseased conditions. The training of medical students appears to be more "objective" and over the period of time they are not trained or exposed to the experience of patients' beliefs and spiritual/religious needs. Thus, they are potentially ignoring an important element that may be at the core of patients' coping and support systems and may be integral to their wellbeing and recovery, relatively less attention has been paid to spirituality, need of a patient's religion, culture etc. Doctors, psychiatrists and mental health clinicians should be required to learn about the ways in which various religion and culture can influence a patient's needs[10]. Multicultural health issues can present challenges to providing quality primary care and General practitioners are in a strong position to be advocates to improve the health of people from culturally and linguistically diverse backgrounds[7].

Today, medical profession is confronted by an explosion of technology and globalization. The medical professionals everywhere are surrounded firmly by diverse cultures with natural traditions. There are wide variations in medical delivery and practice. As a result, physicians find it difficult to meet the responsibilities to patients and society.

Bioethics teaching in medical curriculum

Bioethics education is now considered to be an essential component of educational preparation for health care professionals. Teaching of Bioethics has not been introduced in many universities in many countries. Till 2004, there was no structured curriculum of medical ethics as a separate subject in any of the courses. Some of the issues are dealt in Forensic medicine, where the student is expected to "observe the principles of medical ethics in the practice of his profession". UNESCO Bioethics Core Curriculum can provide an incentive to start introducing such teaching. Its contents are based on the principles adopted in UNESCO[11]. It does not impose a particular model or specific view of bioethics, but articulates ethical principles that are shared by scientific experts, policy-makers and health professionals from various countries with different cultural, historical and religious backgrounds.

Majority of the literature and teaching on healthcare ethics emphasizes on the so called "western" dimensions of ethics which are formulated and applicable to the healthcare profession in the western countries. However, there have been many recommendations that ethics in medicine has to be formulated within the context of the individual socio-economic, geo-political, religious and cultural background of a particular region [12, 13, 14, 15, 16].

There is now increased concern about the knowledge of socio-cultural diversity for the medical professionals both in practice and research. Responding to these challenges, one of the ways to avoid the difficulties is to recognize and emphasize on socio-cultural diversity while teaching Bioethics in undergraduate medical curriculum. The Bioethics curriculum encompasses ethical principles, perspectives, beginning of life, end of life issues, doctor–patient relationship and so one and so forth.

Ethical issues needing socio-cultural background

"*Hooks states that learning process comes easiest to those of us who teach who also believe that there is an aspect of our vocation that is sacred; who believe that our work is not merely to share information but to share intellectual and spiritual growth of our students. To teach in a manner that respects and acres the souls of our students is essential if we are to provide the necessary conditions where learning can most deeply and intimately begin"***.**

Some topics while teaching bioethics like communication skill, doctor-patient relationship , decision making, beginning and end of life issues , autonomy and vulnerability wherein culture of a society and cultural diversities prevail silently. Medical students are not exposed or trained in these areas, result of which is conflicting with problems and dilemma in real practice. This leads to doctor erring. So we believe that when the undergraduate medical students of Asia Pacific region undergo training on bioethics, they should be initially appraised of various socio-cultural diversities of the region and the influence of cultural diversity on ethical issues of above mentioned areas. This will help the students in better understanding, consequently better dealing with the patients in their future real life practice.

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Evaluation of empathy among clinical students at the International Medical University using the Jefferson Scale of Physician Empathy

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Abstract

Background: Empathy is integral to medical practice and promotes better clinical care of patients. Empathy scores among medical students would be useful in predicting levels of care in professional practice. It needs further evaluation with suitable instruments in the local context.

Aim: To determine empathy scores in medical students and if there is a change in empathy scores during their clinical years with regards to age, gender, year of study and religion.

Method: A cross – sectional study involving 150 medical students the Clinical School, International Medical University, Malaysia was conducted using the Jefferson Scale of Physician Empathy (JSPE). Students were randomly selected from the student databank to participate in the study. Variables included gender, age, year of study and religiosity background. One hundred and eighteen consented to participate in this study. A focus group discussion was also done to discuss empathy among medical students.

Results: There was an increase in empathy scores when third, fourth and fifth year medical were compared. The difference between 3rd and 4thyear student was significant (107.04 vs., 112.7, p=0.038) but was not so when fourth and fifth year students (112.7 vs., 118.0, p=0.188) were compared. Female students scored significantly higher (113.46 vs 108.49, p = 0.024). Age and religion had no significant relationship. Except for differences seen in gender, our findings are different from the findings of others. The reason for the increase of empathy scores in the clinical school among medical students is discussed.

Conclusions: The year of study in the medical students and their gender influence empathy scores.

Key words: Medical student, empathy score, year of study, gender

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Introduction

Sympathy is 'putting a person solely on simple emotional sharing towards another' while empathy is better described as the 'ability to take one's perspective and be sensitive towards their emotions and expressions, promoting engagement with one's sense of compassion'[1]. This interaction between physician or caregiver and patient enables the former to provide clinical care at a much higher level than which can be achieved through therapeutic means alone. Difficulties in assessing empathy arise from the lack of suitable instruments and few studies have effectively evaluated this soft skill among medical students. Few researchers allude to improved physician competence and better patient-physician relationship with increased awareness of empathy[2, 3].

Most medical curricula deliver the core contents of the medical curriculum with less emphasis in assessing empathy. One cross-sectional study on empathy among medical student showed a difference in empathy among clinical year students when compared to pre-clinical year students[4]. Others have suggested that clinical empathy should be included in clinical instructions as a dedicated subject[5,6].Various tools have been evaluated to review empathy scores like the Balance Emotional Empathy Scale (BEES), Hogan Empathy Scale and Interpersonal Reactivity Index (IRI). The general consensus is that there are there are' no systemic items that can be used to specifically assess empathy among doctors and future doctors'[7].

The Jefferson Scale of Physician Empathy (JSPE) is designed for evaluating empathy among doctors [8], and medical students[4,9,10]. The JSPE has been used by researchers in several institutes to determine medical students' empathy scores

The JSPE is a validated instrument and this was in our study to evaluate empathy scores among medical students in the third, fourth and fifth year in International Medical University, Malaysia.

Methods

This is a cross-sectional study conducted at the Clinical School, International Medical University (IMU), Malaysia from 17th January until 15th March 2011. Medical students from third year (semester 6), fourth year (semester 7 and 8), and fifth year (semester 9) were recruited. The IMU adopts a five year (10 semesters) medical program. Semester 5 students from third year and semester 10 students from fifth year were excluded due to inconvenience of recruitment as they were resident in different campus locations. Variables studied were students' age, gender, year of study and religion. Students' religion were categorised as Islam, Christianity, Buddhism, Hinduism, and others. Students' age was grouped into 20 – 24; 25 –29 and. 30-35 years.

Stratified sampling was done**.** The sample size was calculated using formula for small population sampling viz.

n = Nz^2pq/(E^2(N-1)+ z^2pq)

Where: n is the required sample size,

N is the population size

p and q are population proportions; P is set at 0.86

z is the value that specifies the level of confidence; z is set at 1.96

E sets the accuracy of sample proportions; E is set at 0.05.

The minimum sample size of 112 was obtained from the formula and this was optimized to 150subjects due to concerns of incompleteness of questionnaires, drop-outs or rejections. Using the proportionate stratified sampling for the year of study, it was estimated that third year students were 50 (33%), fourth year 72 (48%) and fifth year 28 (19%).A complete student list was provided by the Student Affairs Department of the university. The random sampling calculator software was used to generate 150 random numbers which corresponded to students' numbers on the same list.

The questionnaire used was pilot tested on seven volunteers selected from students in the fifth year. They were encouraged to give feedback to enable modification of the questionnaire if necessary.

Demographic data other than names of student, to protect confidentiality, were derived from those who volunteered for the study. The Jefferson Scale of Physician Empathy (JSPE) HP-Version in English was the instrument administered to subjects. The JSPE is a 20-item pen and paper test that is answered on a 7-point Likert scale (1=strongly disagree, 7=strongly agree), the highest score being 140. A higher score indicates higher empathy. There were 10 positive and 10 negative worded items to reduce the tendency for 'constantly agree (or disagree)' with the items. The positively worded items were directly scored based on their Likert weights (e.g., Strongly Agree=7, strongly Disagree=1), but the negatively worded items were reverse scored (e.g., Strongly Agree=1, Strongly Disagree=7).

The HP-Version is more relevant to the study; the S-Version was designed for medical students' view of physicians' empathy. This decision was made after getting feedback from the pilot study.

A second component of the study was qualitative in nature. A 30-minute focus group discussion (FGD) was conducted on 15th March 2011 recruiting seven volunteers, two from third year, four from fourth year of study and one from fifth year of study, to obtain their perceptions, knowledge and utilization of empathy. Definition of empathy, differences of sympathy and empathy, cognitive empathy and emotional empathy were discussed. Participants related their encounters relating to empathy in their clinical encounters. They also gave their views on the impact of personal development, family values and religious views relating to empathy.

The data derived from the quantitative study was analyzed using Statistical Package for Social Science (SPSS) version 16.0. Statistical significance was set at p=0.05. Cronbach's coefficient alpha for the JSPE – HP version in this study was 0.8 which indicated JSPE – HP version had good internal consistency with IMU Seremban Clinical School students. Comparison of gender using t-test and One Way Analysis of Variance (ANOVA) was done between Jefferson Scale of Physician Empathy (JSPE) score and the other variables including year of study, age group and religion. Qualitative data was analysed based on common themes derived.

Results

Of 150 students randomly selected from the students' databank, 118 (79%) voluntarily agreed to participate in our study. All volunteers returned the completed the questionnaires. Forty five were from third year, 54 students from fourth year and 19 students were from the fifth year and the responses were 90%, 75% and 68% respectively (Table 1). Respondents were 41.5% male and 58.5% female with 90.8% of the responders' age was between 20 - 24 years old. This distribution reflected on the overall population in the clinical school (male 42.5%, female 57.5%, 96% aged between 20 - 24)

Table 1. Demographics and Characteristics of the Medical School Classes

Respondents	Third Year	Fourth Year	Fifth Year
Number of Students	94	137	54
Numbers of Questionnaire Distributed	50	72	28
Number of respondents (Response rate, %)	45 (90%)	54 (75%)	19 (67.9%)
Percentage of class surveyed (%)	47.9	39.4	35.2

Table 2 shows the empathy scores by year of study; there was an increase in empathy from third year to fifth year students. Third year students had the lowest empathy scores (mean=107.04), whereas the fifth year class had the highest (mean=118.0). The difference of the empathy between year of study is significant ($p<0.001$).Using Turkey post hoc multiple comparisons of ANOVA, there was a significant difference in increase of empathy between third year and fourth year (107.04 vs, 112.7, $p=0.038$); and between third year and fifth year of study (107.04 vs, 118.0, $p= 0.002$). Increment scores between fourth year and fifth year was not significant (112.7 vs, 118.0, $p=0.188$). When comparing JSPE score by gender using t test, females had a significantly higher empathy mean score as opposed to males (113.46 vs, 108.49, $p = 0.024$,), as shown in Table 3

Table 2. Sample students' mean JSPE score according to year of study

Year of Study	**JSPE (Mean Score)**	**SD**	**95% CI**
Third	107.0	12.1	103.4,110.1
Fourth	112.7	10.5	109.9,115.6
Fifth	118.0	11.7	112.4,123.6

There was no association between religion of students and empathy scores (p=0.868). The age group of medical students did not impact on empathy scores (p = 0.081).

Table 3. Students JSPE mean score by gender

Gender	**JSPE Mean Score**	**Std Deviation**
Male	108.5	12.7
Female	113.5	10.9

Focus Group Discussion

Seven students from different year of study, age, gender and religion from among clinical students of the IMU were generally clear of the definition of empathy. They were also aware of high empathy scores would benefit patients. They also felt that that empathy was different from the act of sympathy, though they couldn't accurately distinguish between the two terms. They perceived that the year of study, age, gender and religion may not uniformly impact on empathy scores. Most felt that only some variables were significant while others did not contribute towards empathy among medical students. For example, they perceived that it was not age but the experience and clinical exposure they gained in the clinical setting that impacted on empathy. With regards to gender, most of them felt that there was no clear link between gender and empathy. They believed, regardless of gender, by involving themselves more in the clinical settings especially in the wards voluntarily, they would gain more experience in handling patients these. Opportunities would enhance both cognitive and emotional empathy according to different scenarios. Most of them thought that it was not one's religion that affected one's empathy level but how one was raised and nurtured during in their upbringing. Moral values imparted by family and teachers had a major impact on one's level of empathy.

Discussion

Year of Study

Using the same instrument (JSPE) in assessing empathy sores, our results are not consistent with some other studies which showed a decline in empathy during transition from pre-clinical to clinical years throughout the years of medical education[4,9,10]. Some of the factors contributing to this were related to personal characteristics of student, physician characteristics, patient behaviour and the health care system.[10] One study in Japan alluded to different curriculum delivery systems, assessment and examination systems, and culture being reasons for increase in pattern of the medical students' empathy[11]. Increase in empathy has been shown in a Korean study as well.[18]Good role models have been shown to be integral to holistic learning in the clinical setting[13].Caregivers' autonomy, hospital guidelines, health insurance regulations, and the tradition of respect for the physician are factors impacting on empathy. The stress of examinations has been quoted as possible cause for lack of empathy among medical students[11]

Age

Age does not contribute significantly towards empathy scores among medical students in this study. This is consistent with the findings of other researches [4, 8]. This is in contrast to the findings of Nune et al (2011) that proposed older students had the advantage of identifying patients' perception better as it was illustrated in the study of undergraduates from five disciplines where those above 27 years of age scored higher in empathy scores than those less than 21years [14].Although we have shown a rising trend among students from semester 6 to 9, the age range was not wide enough for validation [15]. Our study did not include students from semester 5 and 10 for reasons mentioned.

Gender

The significant difference of empathy between male and female medical students is consistent with other studies on medical and dental students and doctors[, 11,16,8].

In a study of children and adolescence by Garaigordobil MA (2009), gender difference was attributed to rearing patterns of males and females as girls apparently tend to be more sociable and develop skills that promote interpersonal relationship and greater warmth than boys[15]. Though arguable, they allude to 'the feminine role having a greater capacity for understanding and sharing others' feelings and emotions unlike the masculine role of the male[15]. Hojat et al. (2002) quote strivers RL, in saying that, 'women are more receptive to emotions-related signals which allow them to enjoy a more empathetic relationship'[8]. Looi quotes Baron Chohen's debatable view that women differ in brain architecture and that there is a 'difference in neural circuitry between the sexes'[2].

Apart from the above factors, other factors that need to be objectively evaluated include work load and stress imposed in medical students involved in the rigorous medical program which may affect the time available for engagement and developing more patient-oriented treatment and care.

Religion

Religion is not a significant factor in assessing empathy among medical students in this study. Data is scarce in this area and there is need for further evaluation. As reflected from FGD, other

components that need to be explored in seeking the impact religion has on empathy are the practice of the faith, social upbringing, rearing pattern and moral values. Associating religion to empathy has its limitations as professed religion can be different to the expressed values and adherence to spiritual practice of the religion. The scope of our study did not permit exploration of religiosity and religious beliefs.

Improvement in Empathy

Bein (2009) suggested various effective approaches to enhance empathy during medical education, including analysing students' videotaped interview sessions with patients, being assigned to effective role models, role-playing and shadowing patients[17].

At the University of California, School of Medicine, San Francisco (UCSF), students watched their own videotapes with both simulated and actual patients during their third year. Students' videotapes with actual patients were analysed and simulated patients would give feedback to students. It was observed that students demonstrated greater awareness of patient emotions after the feedback sessions. It was noted that role models were especially important. Elective placement of learning in facilities for disadvantaged people (school for the Deaf, Down syndrome homes, rural health postings),provide opportunities for students to develop skills in empathy and enhance their skills s forming good relationship with patients and community. The UCSF experience allude to the 'fragmentation of study in the third year, when students are rotated to different wards to experience different specialties' prevents students from forming 'deep bonds with patients'. This is a common malady of most medical curricula as the core contents are delivered within schedule number of weeks. Reviewing the teaching and assessment methods that permits evaluation of communication skills including empathy would overcome some of the deficiencies we see with the conventional medical curriculum[17].

The assessment of empathy as a prerequisite for entry into medical schools has been suggested by Haslam[1] who also proposed that declining empathy among doctors is probably due to 'burnout', lack of control of their work schedules and dissatisfaction at workplace. As one finds means of evaluating empathy as a characteristic of future professionals, determining underlying factors for low levels of empathy could contribute to changes to be made to curriculum contents and suggest remedial measures to improve empathy as it contributes immensely to holistic care of the patient. There are promising comments that empathy education would contribute to increase in this soft skill in health care workers.

Conclusion

Literature review does not show consistent trends in empathy scores in medical education. Although a few studies show a downward trend, empathy scores among medical students in our university appear to increase as students get greater clinical exposure. Women appear to demonstrate better empathy. However, this stratification need to be further evaluated and tested to determine causes of dissimilarity. Empathy is integral to medical education and needs to be addressed in development of the medical curriculum. Empathy enhances physician-patient relationship and improves patient outcome. Assessing empathy scores gives educators a glimpse of prevailing empathy scores among medical students and could trigger a need for addressing the issue during medical education as is being done in teaching bioethics.

The JSPE has been found to be useful in determining empathy scores in our local population. Further research could be refined to reflect on the impact of cultural diversity and religiosity in Malaysia. Suggestion by Hojat (2009)[10] that subjects related to empathy should be introduced into the medical curriculum and be explicitly taught need further discussion[19,20,21].

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Conflict of Interest

None

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Autonomy Revisited: Decision Making in Medical Encounters

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Introduction

Over the past few years, the physician-patient relationship has been transformed from one characterized by strong medical paternalism to one that now reflects strong patient autonomy. Presently patient autonomy has achieved paradigmatic status in the field of ethics[1].

The four principles laid down by Tom Beauchamp and Jim Childress i.e. autonomy, beneficence, non-maleficence and justice forms the main framework for ethical decision making in medicine[2]. The introduction of autonomy to medical ethics has made a great impact and this benevolent change has encouraged the process of ethical decision making. Although all four tenets of medical ethics have equal standing, autonomy is considered to be most important for interventions because of the power of veto[2].

For centuries, medical ethics had been governed by paternalism[3]. It is presumed that healthcare professionals should act in best of patient's interest. In addition, healthcare professional has to abide by law and regulatory provisions of the land. Hence, physician will act in best possible manner to help the patient to overcome turmoil and rigors of illness. This paternalistic model of healthcare and principle of beneficence has been thought to give more power to physicians. It does not go well with the modern pluralistic culture. And this unequal distribution of power has left patients at a disadvantage. However, exercising paternalism is difficult when we don't have precise idea of patient's best interests.

According to Katz, the idea of patient's right to share responsibilities of decision with his physicians was never made part of the essence of medicine[3]. With rising democratic, pluralistic culture and educational status of the society, individuals are getting more aware about their rights than before. Easy access to internet based knowledge makes patient more informed about their diseases and treatment options. This has reduced the knowledge gap between patients and doctors. All this has given the patient more say in decision making about their illnesses. Therefore, an attempt is being made in this article to review Autonomy in various contexts, its conflicts with other principles in healthcare and ways to resolve these conflicts.

Keywords- Autonomy, Paternalism, ethics, conflict of ethical principles

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The term autonomy was first introduced to ethical theory by German Philosopher Immanuel Kant[4]. In healthcare, autonomy can be viewed as the freedom to make decisions about one's own body without the coercion or interference of others. Autonomy is freedom of choice or self-determination, a basic human right[5]. It is the health professional's duty to respect autonomy of the patient. The essence of this principle is in allowing an individual the freedom of choice and action. Some bioethicists consider that patients should be allowed to make their own choices about their treatment even if it is clear for all parties involved that others would be in a better position to make choices that would serve the patient's wellbeing[6].

The Hippocratic Oath has ruled the ethics of healthcare since historical times. But introduction of Four Principles has necessitated a change in our thinking of ethics. The Hippocratic Oath and the four principles by Beauchamp and Childress are similar excepting one stark difference[7]. While the Hippocratic Oath assumes a position of paternalism, principle of autonomy laid down by Beauchamp and Childress considers respect for the patient's will. The Hippocratic Oath is based on principle of beneficence i.e. doing good to the patient. Whereas Autonomy considers patient's beliefs, desires, and choices while making decisions regarding the treatment. Social, cultural, religious values of the patient are also considered and respected. The autonomy model of clinical decision making respects dignity of human persons and it also have respect to privacy, the establishment of their own values and treatment plans based on information and reasoning.

The principle of respect for persons divides into two separate moral requirements: the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy[8]. Competent individuals can choose voluntarily and intelligently from among various options whose relative risks and benefits, their personal physicians have fully explained to them. Children and some individuals with diminished decisional capacity cannot choose or refuse treatment. These Persons are not capable of making competent choices since decisions exercised by them can harm themselves or others. Thus, according to some philosophers, patients' autonomy can be restricted if there is a threat of very severe harm to patients wellbeing while others seem to accept no limits to patients' autonomy when there is no danger of harming others[6].

The prerequisite of autonomous decision-making process is that it must be free of coercion or coaxing. In order for a patient to make a fully informed decision, patient must understand all risks and benefits of the procedure and the expected outcome.

Gillon outlines four specific areas where a doctor may act without regard for the patient's autonomy[7, 9]:

- Patients have given their prior consent that the doctor can make decisions as they see fit.
- Respect for one patient's autonomy directly conflicts with another patient's autonomy or safety, or where it could conflict with an aspect of justice.
- Where someone used to have autonomy but no longer does.
- In an emergency where a patient's life is at risk.

In health care settings, the principle of autonomy translates into the principle of informed consent: the physician shall not treat a patient without the informed consent of the patient or his or her lawful surrogate[10]. The informed consent should be obtained after providing all relevant information to the patient like diagnosis, treatment options with their pros and cons and expected outcomes.

Criticism of patient's autonomy

Paternalism was the accepted model of the doctor patient relationship for most of the history of medicine. In recent times, these conditions changed so radically that the more objectionable features of medical paternalism have begun to be protested against. But in practice, the exercise of autonomy in the medical context is frequently rather messier and more complicated than the prevailing bioethical theory and law would have us believe[11].

Individual patients will have different intellectual capabilities and understanding of their illness. It is therefore mandatory to tailor information provided to the individual patient and the current situation[12].Also in case of emergency situations, instant decisions are needed. In these situations and others, the proper implementation of patient autonomy is less than clear. Explaining all the risks involved in therapy may arouse a state of confusion or fear and patient may end up making wrong decisions. Giving inadequate information defies the process of autonomous decision making.

On a philosophical basis the principle of total autonomy contradicts itself when applied to society. Total autonomy of one individual has a negative effect on autonomy of other individuals. Modern democratic society has designed rules and laws to create a fair way of living and it permits only restricted autonomy[12]. Individuals do not live isolated from society and the moral principles of a given social, cultural, legal and religious organization have authority and influence over people's lives and autonomous choices. No one is free from external influences such as the family or the moral community to which one belongs. The context of getting sick sets up limits, at different levels, to the exercise of autonomy[3]. Thus ultimately one cannot be free from coercion or coaxing. Thus it might seem that our right to be autonomous is more myth than reality.

Although the principle of autonomy is widely accepted by all, its application in certain situations can be problematic. Choice of treatment option, imparting information about disease to relatives, provision of treatment to terminally ill patients, declaring poor prognosis to patients and relatives, withholding or withdrawal of treatment in a patient with multiple co-morbidities, deciding incompetency to exercise autonomy, role of surrogate decision makers, abortion, euthanasia-death with dignity, distributive justice are the some of the ethical dilemmas involving autonomy[13]. Patients' wishes, patient's financial interests, obligations on part of physician and patient and family interests also contribute to these conflicts. These ethical dilemmas are complex to resolve and conflicts may arise between principles of ethics as something good has to be given up or some decisions has to be taken which may add to the sufferings of patient.

The patient autonomy model does not pay sufficient attention to the impact of disease on the patient's capacity for autonomy. One cannot assume that autonomy is fully restorable or preservable in cases of serious illness. Senile patients may wax and wane in competence. Acutely and desperately ill patients with severe trauma and burns may vacillate in their desire to live. Hasty decisions not to treat out of deference to the principle of autonomy may be more damaging to the patient's ultimate best interests than some degree of paternalism. This "variability of context" is, therefore, an important moral limitation on autonomy[14]. It demands careful assessment in each case, while remaining sensitive to the moral obligation to respect patient autonomy. Some degree of soft paternalism may then be exhibited to protect the patient. But to what extent autonomy is to be respected and when clinician shall take control of patient's treatment in favour of beneficence is a very tough choice.

Healing as a moral component of the physician-patient relationship is not given sufficient weight in the autonomy model. The physician's task goes beyond the prevention of harm. There has been concern that elevating the role of autonomy will lead physicians to adopt a laissez-faire attitude towards patients, lessening physicians' sense of responsibility[1]. Additionally, over promoting of patient autonomy may compel the patient to make decision about their health care (mandatory autonomy). Whether on some occasions we ought to recognize a patient's prerogative thoughtfully and explicitly to waive personal control and delegate that authority to others, including the physician needs debate.

As pointed out by Christopher Meyers, patient lives heteronomous rather than autonomous life most of the time. Yet at critical times, when health care decisions are to be made, a paradigm shift occurs making a traumatic situation even harder[15]. The physician patient relationship is governed by relationship of trust and respect between them, a fundamental condition for the cure. This is lacking in autonomy model. More value is given to the process of decision making and not to the outcome of the decision in autonomy model.

Autonomy reflects only a relative value, since it is submitted to individual fragilities and ambiguities. Therefore, the principle of autonomy keeps important issues open and it should be considered only as a key principle within a system of moral principles[3].

In summary, the notion of autonomy commonly employed in medical ethics and practices is inadequate on three fronts: it fails to properly identify nonautonomous actions and choices, it gives a false account of which features of actions and choices makes them autonomous or nonautonomous, and it provides no grounds for the moral requirement to respect autonomy[16].

Resolving approaches

Paternalistic approach is not acceptable in today's world. But autonomy sometimes conflicts with beneficence and/ or non-maleficence. After reviewing multiple approaches to resolve these ethical dilemmas, possible options may be considered.

Current emphasis is on maximizing patients' autonomy by ensuring their independence from others; instead Schneider urges the ideal way is an optimizing of patient autonomy. Optimal, rather than maximal, involvement of patients in decision making would take into consideration particular variables pertaining to the patient and to the medical context[11].

Decision making moves steadily away from both patient and physician, toward faceless third parties like insurance providers. Schneider calls for less emphasis on the process of medical decision making in favour of a bioethical perspective that focuses on the results of that process[11].

While autonomy is regarded highly, doctors often give equal weight to other considerations, such as their perception of what is in the patient's best interest and guidelines from professional bodies[1]. Formulating ethical codes and or professional guidelines may serve as one of the modality to resolve ethical dilemmas.

Another approach found is four topics approach described by Jonsen et al[17,18]. It simultaneously considers multiple principles of ethics with emphasis on context. In four topic method, each topic: medical indications, patient preferences, quality of life and contextual features is a set of questions

to be considered in analysing the problem or case. Four topics model is useful not only for ethically challenging cases but for any clinical encounter.

Modern medicine incorporates autonomy to patient in making choices as well as necessary beneficial paternalism. The former occur when the diagnosis and options are clear and well documented. The latter occur when not enough is known about a disease and its prognosis, when no therapeutic modality has a clear edge, or when an existing therapy has marginal or dubious benefit[14]. In these cases, physicians may be forced to recommend.

Finally, it can be concluded that none of the available models of ethical decision making is perfect. And search to find out the best fit will go on. Neither autonomy of the patient nor beneficial paternalism can be rejected. Both are complimentary to each other rather than competitive. A judicious mix of the two is essential for ethical decision making.

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Status of Bioethics: in the curriculum of undergraduate health science and allied sciences.

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Ethical practice in Medicine and allied health sciences has not been able to keep up with the rapid transition in growth in health care scenario in India which includes upcoming advances in medicine such as development of prenatal diagnosis, in-vitro fertilization and stem cell therapy. Currently the ethical practice in India is governed by individual moral values, local practices, personality types, social background and social structure. The current undergraduate curricula for MBBS, BSc Nursing and allied health sciences including laboratory medicine are far from adequate in terms of formal education in code of Medical Ethics. Different areas in developing the soft skills like ethical conduct of the budding physicians and medical practitioners have not been addressed.

The Bachelor of Surgery and Bachelor of Medicine (MBBS) curricula in India as prescribed by the Medical Council of India (MCI) and the current curriculum does not include formal structured teaching module of ethics and its principles in the undergraduate MBBS curriculum of India. For many years, administering the Hippocratic Oath has been expected to take care of this important aspect of healthcare delivery and practice. The Medical Council of India (MCI) has published "Regulations relating to the professional conduct, etiquette, and ethics for registered medical practitioners.[1]Once an MBBS graduate, the doctors are governed by Code of Medical Ethics 2012 enforceable by IMCA 1956 act, but there is no uniform delivery mode or entraining of doctors regarding this code of Ethics, neither is it a mandatory requirement to undergo sensitization to practice this Code of Medical Ethics, 2012.[2]

However it is mandatory for all doctors to practice code of Medical Ethics, and it is assumed every doctor should be aware of the code of Medical Ethics without any formal sensitization. A graduating doctor is required to sign a document during registration with the MCI to agree and abide by the rules and conduct themselves according to the code of medical ethics "I shall abide by the code of medical ethics as enunciated in the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002." In a country like India where legal liability in medical profession is a new science, it remains to be seen how many actually remember to abide by those rules. Furthermore when one reads the code of ethics it is repeatedly mentioned that "a Doctor shall conduct himself ethically".

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Ethical principles of respect, freedom, beneficence, non-malpractices, veracity, justice rights, fidelity and confidentiality however are not mentioned as different principles of ethics. Neither the bachelor's degree course nor the Post Graduate curricula for Doctorate of Medicine and Doctorate of Surgery degrees and other post graduate diplomas has a structured prescribed course for Ethics in India.[3]

WHO defines Physiotherapy profession as an independent profession with autonomy, "Physiotherapists assess, plan and implement rehabilitative programs that improve or restore human motor functions, maximize movement ability, relieve pain syndromes, and treat or prevent physical challenges associated with injuries, diseases and other impairments. They apply a broad range of physical therapies and techniques such as movement, ultrasound, heating, laser and other techniques. They may develop and implement programmes for screening and prevention of common physical ailments and disorders." [4]

Responsibilities of a physiotherapist have increased in an era of evidence based practice. Scientific inquiry skills and integration of evidence-based principles into clinical decision-making are fundamental in the curriculum. Students develop their abilities to critically analyze and problem-solve, integrating information from empirical, scientific literature and practical experience.[5]

Physical therapy is practiced across a continuum of care where therapeutics is delivered in acute, rehabilitative, chronic and community settings to address impairments, disabilities, and in some instances, handicaps. Students learn and develop the skills essential to become health care professionals. Professional values, responsibility, accountability, sensitivity and ethical attitudes towards both the consumer and health care community are emphasized. Students learn to evaluate and consider the implications of their professional actions. The existing curricula for Physical therapy graduate course does not have a structured course on Ethics to better equip physiotherapists with the interactional skills needed to apply this insight, knowledge and reasoning to human clinical care.[6]

Teaching ethics to student aims to sensitize students to value issues and teach them moral reasoning. They should be able to highlight the uniqueness of patient- doctor relationship and place profession in broader, social and professional perspective.[7]

Medical Laboratory is a crucial part of any health care structure. International Federation of Clinical Chemistry realised that there were many ethical issues unaddressed as there were no defined protocols and policies for ethical practice in laboratories. With the changing role of laboratory in patient management and inclusion of genetic and newer biochemical testing led to new ethical issues like maintaining a balance between potential benefit to the community at large versus protecting individual rights. The ethical policy, addressing such moral complications, has been developed in some countries, while in most countries there were no codified protocols and defined policies. Consequently, the IFCC (International Federation of Clinical Chemistry) proposed a generic ethics framework, and included the four fundamental guiding principles: autonomy, justice, non-malfeasance and beneficence in 2007.[8]

Currently, in India laboratory practice is guided by good laboratory practices but there are no defined uniform curricula in laboratory science education and practice for knowledge and practice of ethics. Accreditation bodies lay stress on the competency of processes in the laboratory but not on ethical

practices. The Laboratory sciences are no different from the Medical counterparts in India. The closest to ethical practices guidelines in the laboratory is practicing the “principles of good laboratory practice”. [9,10]

Professional nursing has expanded rapidly in this modern era. This profession includes expertise specialization, autonomy and accountability both from legal and ethical perspective. It has been expanded to interact with legal and ethical principles. An area of concern in curriculum includes professional nursing practices, legal issues, ethical issues, labour management and employments. The Indian Nursing Council, that regulates the nursing curricula has prescribed the International Council of nurses codes for nurses which serves as a means of self-regulation and a source of guidelines for individual behaviour and responsibility. This curriculum as opposed to the other health care science curricula introduces the concepts of ethical principles in nursing care at undergraduate level. The nursing graduates are familiarised with the principles and concepts of ethics inclusive of “respect for person, autonomy, freedom, beneficence, non mal practices, veracity, justice, fidelity and confidentiality”.[11]

This early exposure to ethical principles among nurses at graduate levels does not eliminate the ethical dilemma faced during nursing practice, but it is reassuring that the course has been designed to equip them to take the correct decisions. [12,13]

The code of professional conduct for nurses is critical for building professionalism and accountability. Ethical consideration is vital in any area dealing with human beings due to the represent value, right and relationship. The nurses must have professional competence with the moral obligations. [13]

Since 2004, the Indian Council of Medical Research (ICMR) and the Department of Science and technology; Government of India has been conducting sensitisation, awareness and training workshops for students as well as faculty in ethical research throughout the country. ICMR has published “Ethical Guidelines for biomedical research on human participants” in 2006 guiding. This has created a tremendous interest in medical ethics among the students and the medical fraternity.[14]

These trainings and efforts of the ICMR and the UNESCO bioethics core- curriculum translated into a recent drafting of the vertically integrating model for teaching bioethics to the medical undergraduates, a pragmatic approach for integration of bioethics teaching into the existing regular medical curriculum.[15]

Current status of ethics in undergraduate curricula in health and allied sciences in India is work in progress and will need a lot of proactive effort from the grass root to the centre in the future. There is apparent lack of emphasis on neutral unbiased approach that a doctor needs to adopt in our existing textbooks and practice. These doctors should be sensitive while dealing with victims of domestic violence and be gender neutral and apolitical. These are not included in the formal textbooks that our students are currently using. The role of mentor, advisor, family friends and faculty has not been adequately addressed in our textbooks. Learning of ethics and ethical practice so far is experiential and guided by individual moral, societal and religious inclinations. [16, 17]

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Attitude of medical undergraduate students' in treating homeless individuals and bank executives: a comparative study

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Abstract

This study analysed undergraduate medical students' perceptions to undertaking medical procedures like taking a medical history and performing a physical examination, performing surgery, performing mouth to mouth resuscitation, drawing blood and performing autopsy of bank executives and a homeless individual. The results showed that there was a decrease in the medical student's interest to undertaking the specified medical procedures in all the five cases. A significant difference was seen only for taking a medical history and performing a physical examination ($p < 0.04$) and for performing mouth to mouth resuscitation ($p < 0.0001$), while it was insignificant for procedures like performing surgery, drawing blood and performing autopsy. Analysis also showed that there was no association between demographic factors like gender, domicile, religiosity and orthodoxy with the rating scale for the various aspects in both homeless and executives. Stratification of the data in accordance to the volunteer's year of study and exposure to patients in clinics (preclinical and clinical) showed that the student's pursuing clinical courses had less willingness to treat the homeless ($p < 0.02$ to 0.003) and was statistically significant. The results indicate a need for critically analyzing the reasons for the divergence in the opinion of the undergraduate medical students and plan a suitable teaching program to incorporate empathy and moral ethics towards the welfare of the destitute and the marginalized population.

Key words: homeless individuals, bank executives, Willingness to treat.

Introduction

Homeless persons, that is individuals without permanent housing or who may live on the streets; may stay in a shelter, mission, single room occupancy facility, abandoned building, or vehicle; or who are in any other unstable or nonpermanent situation is globally a common thing in all races and ethnicities (Khandor et al., 2011) and are highly stigmatized as troublesome and undesirable patients by the healthcare professionals (Habibian et al., 2010; Gelberg et al., 1990; Crandall et al., 1997; Masson et al., 2003).

When compared to the general population homeless people have poorer health and often experience a disproportionate burden of acute and chronic health issues, including concurrent mental health and substance use disorders (Khandor et al., 2011, Frankish et al., 2005; Hwang 2001; Goering et al., 2002). Complex, advanced medical problems and psychiatric illnesses, exacerbated by drug and alcohol abuse, in combination with the economic and social issues like lack of housing, transportation facilities, lack of trust as well as having other basic unmet priorities make this subset

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of the population a unique challenge for the health care system, local communities, and the government (Gelberg et al., 1990; Khandor et al., 2011; Habibian et al., 2010). All these things contribute significantly to higher mortality rates in these populations (Cheung et al., 2004; Hwang et al., 2000, 2009, 2010; Roy et al., 2004) and the actual data on its impact in society is missing especially in India.

Despite their increased need for care, many homeless people face barriers to primary health care and frequently have unmet health needs (Connelly and Crown, 1994) and previous studies have reported that the homeless people experience a sense of being unwelcome in health care settings (Gelberg et al., 1990; Crandall et al., 1997; Habibian et al., 2010; Fine et al., 2013; Wen et al., 20076; Lester et al., 2001). Additionally, studies have also shown that a lack of appropriate training for medical professionals is also a major barrier for homeless individuals to seeking medical care (Gelberg et al., 1990; Crandall et al., 1997; Fine et al., 2013; Wen et al., 20076; Lester et al., 2001). In a very ideal proposition access to medical treatment should not depend upon an individual's ability to pay but on the severity of the medical condition (Connelly and Crown, 1994). For any remedial changes to be proposed and implemented it is necessary to access the attitude of healthcare students towards treating homeless people. Therefore to provide some data in this important area, a study examining medical students' attitudes was undertaken with two diametrically opposite social groups the bank executive with the homeless individuals.

Materials and Methods

This study is a single centre study and was conducted under the aegis of the UNESCO Bioethics South India Unit at Father Muller Medical College, Mangalore, India. The study was approved by the Institutional Ethics Committee of the College and was carried out during January to April 2014 after the approval. The inclusion criteria included students pursuing their medical undergraduate degree in compliance with the "Ethical principles for medical research involving human subjects" section of the Helsinki Declaration. The students were explained the objective of the study by a student investigator (AT) and also that their participation was completely anonymous and voluntary. The endeavour was done after a scheduled lecture with no prior information or announcements in order to minimize response bias. The students were informed that their participation was voluntary and that they deposit the filled questionnaire in the collection box. Written consent was obtained on separate sheet from all the willing participants before the administration of the questionnaire. The volunteers were also requested not to write their names or leave any identification marks on the study questionnaire to maintain their anonymity.

The structured questionnaire distributed was based on the earlier study of Milikovsky and co-workers (2013). The questions explore the commitment and willingness of medical students to treat patients. The first part sought demographic information including gender, domicile, religious beliefs and regularity in prayers. The second part consisted of a chart listing important medical procedures like taking a medical history and performing a physical examination, drawing blood, performing surgery and performing mouth to mouth resuscitation that are performed on patients. The respondent was asked to rate on a scale of 1–4 (High willingness = 4; medium willingness = 3; low willingness = 2 and only under pressure = 1.

Statistical analysis

Data was entered in Microsoft excel and analysed on the online based Vassar Stats statistical program. All quantitative variables are illustrated through mean and standard deviation and the "*t*" test was applied. The Kruskal–Wallis tests were used to find an association between the gender, domicile, religiosity and orthodoxy with the rating scale for various medical procedures. A p value of < 0.05 was considered significant.

Results:

Two hundred and fifty three out of approximately 438 (57.76%) students in the college completed the questionnaire. Stratification in accordance to the year of study showed that 48.22 % (122/253) of the volunteers were in preclinical (1 and 2nd year) years of study, 51.78% (131/253) in the clinical (3rd and 4^{th} and junior residents) years of study. Additionally on a gender based groupings it was observed that of the 253 volunteers, 79 were men and 174 were women. The details on the volunteer's domicile, religious beliefs and regularity in prayers are enlisted in table 1. With respect to the attitude and willingness in providing medical care and procedures in bank executive and a homeless individual the details are in table 2. Statistically significant difference was seen only for taking a medical history ($p < 0.04$) and for performing mouth to mouth resuscitation ($p < 0.0001$). The Kruskal–Wallis analysis for association showed that gender, domicile, religiosity and orthodoxy had no correlation with the rating scale for the various medical procedures.

In addition, to further understand the willingness of preclinical with clinical curriculum pursuing students, the data was accordingly stratified and analysed longitudinally (between the two sets of student population) for their willingness to treat the homeless individuals and beggars, and the bank executives. The results indicated that the student's pursuing clinical courses had less willingness to treat the homeless individuals and beggars ($p < 0.02$ to 0.003) when compared to the preclinical students and the data are represented in table.

Discussion:

Clinical practice is an important part of medical education and an ideal scenario would be to inculcate teachings that will enhance both clinical expertise and ethical behaviour in the students (Fine et al., 2013). In fact examples are suggestive to the fact that the healthcare professionals' empathy, moral behaviour, attitudes and beliefs about the underprivileged and destitute patients has an important effect on therapeutic interactions and the patient's well-being, while obnoxious behaviour has the opposite effect (Fine et al., 2013). Of importance in the observation that people with transmissible diseases (like HIV), schizophrenia, alcoholics and substance abusers and from the marginalized under privileged groups like the refugees, gypsies, homeless people are mostly neglected (Habibian et al., 2010; Gelberg et al., 1990; Crandall et al., 1997; Masson et al., 2003).

Global studies have shown that homeless people are frequently stigmatized as troublesome and undesirable patients by the healthcare professionals (Habibian et al., 2010; Gelberg et al., 1990; Crandall et al., 1997; Masson et al., 2003) Additionally the physicians' negative attitudes towards homeless people and lack of appropriate training for medical professionals are major barriers for homeless individuals seeking medical care (Masson et al., 2003; Wen et al., 2007; Lester et al., 2001; Fine et al., 2013).

In our study it was observed that when compared to the bank executive the medical students had a decreased preference in undertaking medical procedures like taking a medical history and performing a physical examination, performing surgery, performing mouth to mouth resuscitation, drawing blood and performing autopsy of an executive and a homeless individual. However significant difference was seen only for taking a medical history and performing a physical examination ($p < 0.04$) and for performing mouth to mouth resuscitation ($p < 0.0001$).

A critical analysis of the data indicate that when compared to any other medical procedure the students were less willing to perform mouth resuscitation and that also extended to the executives. These observations are in agreement to the earlier reports of Milikovsky and co-workers (2013) who have also reported that mouth resuscitation was lack of total willingness especially in patients with swine flu, HIV positive status, TB and SARS. The lack of association between the gender, domicile, religiosity and orthodoxy with the rating scale for taking a medical history and performing a physical examination and performing mouth resuscitation indicates that none of these demographic details have a role in the degree of willingness to the various medical procedures in the homeless.

With respect to willingness to treat based on the student's academic year of study (preclinical with clinical curriculum) it was observed that the students in clinical curriculum had a lesser willingness to treat homeless individuals and beggars was statistically significant for taking medical history ($p = 0.032$) and surgery ($p = 0.02$) and a trend for autopsy ($p = 0.09$). With respect to mouth to mouth resuscitation and performing an invasive procedure there was no trend or statistical significance indicating that both preclinical and clinical students had almost similar preference for conducting these procedures in the homeless individuals and beggars (Table 3). With respect to the bank executive it was observed that the students pursuing clinical course had less willingness in taking medical case history (Table 3) and this may be due to the fact that most of the times case taking is done by a trainee or a nurse. The second most important aspect was that when compared to the preclinical students, the clinical students also had less interest in performing surgery on bank executive ($p = 0.08$) and this may possibly be because many students prefer non-surgical branches like medicine, radiology etc.

The present study, to our knowledge, is the first detailed examination of medical undergraduate student's attitudes towards performing medical procedures in the individuals and beggars people in an Indian context. Together our data demonstrate that the willingness to treat profile of students is variable with highest scores being observed in students pursuing their preclinical course than the ones pursing clinical subjects and working as residents in the hospital wards. This data is consistent with studies from other parts of the world where studies have shown a decline in medical student's empathy scores over time (Youssef et al., 2014). It is quite possible that this factor could have had a role in the changed opinion of the senior students pursuing their clinical programs in the medical curriculum. This can be rectified partly by teaching ethics as a separate subject which our unit has initiated. The biggest drawback of this study is that it was carried out in a single institution where most of the patients treated to are from the lower economic strata and these results may not be transferable to other medical student populations. A multicentric qualitative and quantitative study is being planned to ascertain the exact cause for the apathy towards the homeless individuals and beggars is being planned.

Table 1: Demographic details of the student volunteers

Particulars	**Choices**	**Percentage**	**(Numbers)**
Gender	Males	31.22	(79/253)
	Females	68.77	(174/253)
Year of study	Students in pre-clinical subjects (1 and 2nd year)	48.22	(122/253)
	Students in clinical subjects (3rd and 4th year and residents)	31.62	(131/253)
Domicile	Rural	22.53	(57/253)
	Town	30.03	(76/253)
	City/Metro	46.24	(117/253)
	Unanswered	1.58	(4/253)
Orthodoxy	Very Orthodox	3.95	(10/253)
	Medium Orthodox	67.98	(172/253)
	Not Orthodox	25.29	(64/253)
	Unanswered	3.16	(8/253)
Regularity of Prayers	Daily	51.77	(131/253)
	Weekly	34.38	(87/253)
	Monthly	9.09	(23/253)
	Never	3.16	(8/253)
	Unanswered	1.97	(5/253)

Table 2: Willingness rating to perform the discussed procedures on bank executive and homeless patient

	Bank Executive	Homeless individuals	t value	p value
Medical History Taking	3.66±0.57	3.55±0.67	2.05	0.04 Significant
Surgery	3.62±0.66	3.59±0.73	0.57	0.56
Resuscitation	3.29±0.88	2.90±0.98	4.67	<0.0001 Significant
Blood drawing	3.73±0.57	3.67±0.56	-1.17	0.24
Autopsy	3.41±0.84	3.35±0.81	0.69	0.49

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Human Rights and Nigerian Prisoners- are Prisoners not Humans?

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ABSTRACT

In Nigeria, just like many other parts of the world, one of the most extensively discussed issues on the public agenda today is the increase in prison population. The aims of imprisonment are protection, retribution, deterrence, reformation and vindication. Investigations revealed that the prison services have been neglected more than any other criminal justice agency in Nigeria. For example, most of the prisons were built during the colonial era for the purpose of accommodating small number of inmates. Human rights are the basic guarantees for human beings to be able to achieve happiness and self-respect; consequently in most jurisdictions, the Human Rights Act confirms that these Rights do not stop at the prison gates. However, most states fail to meet the human rights obligations of their prisoners. On health, for example, every prison should have proper health facilities and medical staff to provide dental and psychiatric care among others. This article discusses Nigerian prison system and challenges, trends and the related human rights and ethical issues in Nigerian prisons. Some of the unmet needs of Nigerian prisoners include, *inter alia*, living in unwholesome cells, delayed trial of inmates, lack of voting rights, access to information, lack of conjugal facilities for married prisoners, poor and inadequate nutrition, poor medical care, torture, inhumane treatment and the need to protect prisoners in a changing world. The present report has policy implications for reforming prison services in Nigeria, and countries that sing from the same song sheet with Nigeria on prison services, to conform to the fundamental human rights of prisoners in 21st century.

Key words: Nigerian prisoners, Human Rights, Ethical issues, Policy implications, Prison reform

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INTRODUCTION

There are different ways of punishing offenders in different societies, imprisonment is one. The aims of imprisonment are protection, retribution, deterrence, reformation and vindication. Prison authorities in their treatment of prisoners should encourage personal reformation and social rehabilitation (Jenkins, 2002; HRP, 2005; Walmsley, 2013).

There are over 10 million men, women and children held in penal institutions throughout the world, mostly as pre-trial detainees/remand prisoners or as sentenced prisoners for different forms of offences; and a good number of them may be innocent or prisoners of conscience (Jenkins, 2002; HRP, 2005; Walmsley, 2013) .

There are total of 54,144 prisoners in Nigeria (including pre-trial detainees and remand prisoners), prison population rate per 100,000 of national population is 32, pre-trial detainees rate is 69.5%, female prisoner rate is 2.0% and juvenile/minor rate is 1.0% (Walmsley, 2013). These high rates should be a matter of grave public concern. Most states (Nigeria inclusive) fail to meet their human rights obligations when it comes to their prison systems (Joshua, 2007; Ikuteyijo and Agunbiade, 2008).

In Nigeria, just like many other parts of the world, one of the most extensively discussed issues on the public agenda today is the increase in prison population (Joshua, 2007). Investigations revealed that the prison services have been neglected more than any other criminal justice agency in Nigeria. In addition, one of the most daunting challenges confronting our criminal justice system today is the overcrowding of our prisons (Joshua, 2007).

Human rights and ethical issues in prisons are topical and of public health importance, there has been call for prison reform in many countries especially in the developing countries including Nigeria (Joshua and Mahmud, 2006; Joshua, 2007; Ikuteyijo and Agunbiade, 2008). There are indications in many countries that current economic difficulties are forcing politicians and public commentators to acknowledge that prisons cannot continue to expand in the way they have done in recent years.[2]There has been a continuous out cry for alternatives to imprisonment, such as community service and house arrest.

Prisoners are usually voiceless, forgotten and marginalized segment of society and in many countries the majority of prisoners come from minority and marginalized groups. Significant number of them are mentally ill or drug and alcohol abusers (Goyer, 2003).

This paper examines Nigerian prison system and challenges, trends and the related human rights and ethical issues.

METHODOLOGY

A literature review on the above mentioned areas was carried out over a fifteen year period (1991 to 2013) in relation to the words; Nigerian prisons and prisoners, human rights, ethical issues and challenges, prison reform and policy implications.

Results and Discussion

Nigerian prison system

General Information

Nigerian prison system is a federal government owned institution with a staff strength of 27,000 taking lawful custody of over 45,000 inmates nationwide out of which 36,000 (80%) are those awaiting trial (FMIA, 2002).There are 144 main prisons and 87 satellite prisons; 1 prison camp and three borstal institutions.

Studies revealed that the prison services have been neglected more than any other criminal justice agency in Nigeria and most of the prisons were built during the colonial era for the purpose of accommodating little number of inmates. For example, Kaduna convict prison was established in 1915 to accommodate 550 inmates and Zaria prison in 1948 to accommodate 400 inmates (FMIA, 2002; Labo, 2004; Joshua and Ogboi, 2009).

The prisons are congested and overcrowded with inadequate prison staff (Joshua and Ogboi, 2009; Audu et al., 2013). All these accommodating cells overcrowded, with prisons becoming breeding grounds for diseases such as HIV/AIDS, viral Hepatitis, scabies and tuberculosis among others (Joshua and Ogboi, 2009; Sabitu et al., 2009). There have been reports of prisoners dying in custody from preventable diseases and also women giving birth in prison (Joshua et al., 2007).

The prison is also characterized by occurrences of risky sexual and non-sexual practices important in the spread of HIV/AIDS and other related diseases (NLRC, 1983; Odujirin and Adebayo, 200; Sabitu et al., 2009). There are periodic health talks and HIV screening but no pre-admission counselling and screening of inmates for HIV in any of the prisons.[11]

Trends in the prison

The average number of Nigerians who have been incarcerated over the past three decades from when HIV was discovered has been increasing (Joshua and Ogboi, 2009; Audu et al., 2013).

Over the years the healthcare of prisoners require a sound ethical frame work in the area of quality of care, equivalence of care, recruitment and retention of prison staff and balance. The capacities of the prisons are also getting over stretched. For example, Kaduna Convict Prison as at its establishment in 1914 was to accommodate 550 prisoners but as at 2007 the total inmates were between 800 and 1000 (Joshua et al., 2007) and provision of appropriate accommodation and basic amenities such as food, soap, toiletries, has also been in severe shortage over the years.

Meeting comprehensive health needs of prisoners is important and in a study conducted in 2007 in Kaduna found that a prisoner died of Tuberculosis (Tb) which would have prevented with treatment (Joshua et al., 2007). The deceased could not be started on anti-Tb drugs because he could not pay N600 ($4), the cost of plain chest X-ray necessary before the commencement of the drugs.

Change in the number of awaiting trial inmates also showed a special trend. For example, in 2007 the number of prisoners awaiting trial in Kaduna convict prison constituted about 80% but in 2012 it was 67.3% (Joshua and Ogboi, 2009; Audu et al., 2013). This decrease could be as the result of the

wakeup call by civil society and the increasing advocacy for community service and house arrest as alternative to imprisonment for minor offences.

Challenges in Nigerian Prisons

Living in overcrowded, dilapidated, filthy and cruel environments where corporal and sexual abuse are common[11.14]The Nigerian Law Reform Commission reported that:

"Nigerian Prisons are too congested, and poor ventilation is one of their glaring features. Prisoners and detainees are cramped together in cells with no adequate accommodation facilities… hardened criminals are made to live together with first offenders…. Prisoners sleep in double decker beds with no mattresses and pillows provided. In these congested cells, not all prisoners are fortunate to be provided with beds. The unlucky ones are made to sleep on the dirty, bare floor"(NLRC, 1983)

Delay trials of inmates- In most cases remand prisoners who have not been found guilty of any crime suffer the worst conditions. In some countries including Nigeria, prisoners are held awaiting trial for many years, often longer than the maximum sentence for the charge (Labo, 2004; Joshua et al., 2007). A respondent was quoted:

*"We are kept here for long time without trial and even bible say there is time for everything. There is time that you feel like having sex and if you cannot remove your mind from it, if you cannot control yourself, you will start misbehaving and involving yourself in things like homosexuality, masturbation or do one thing or that to remove sperm from your body"(*Audu et al., 2013)

Mentally deranged persons in prison- It is not unusual to find persons who should be cared for by the mental health systems mistakenly ending in prisons. Reports showed that up to 1/3 of prisoners have some identifiable psychiatric disorders.

Lack of access to comprehensive medical care- Loss of liberty must not entail the loss of a right to quality medical treatment of a proper ethical and clinical standard. The concepts of equity, and justice must remain even in a prison healthcare system. The prevalence of HIV/AIDS among prison inmates has remained higher than the national average (Iwoh, 2004; Chima, 2009; Joshua and Ogboi, 2009).

Poor and inadequate feeding of prisoners- There is a direct relationship between nutrition and health. The sentenced prisoners are being fed better and looking healthier than those awaiting trial and inadequate provisions of food lead to exchange of sex for food and other basic materials by inmates. Exchange of food for sex due to hunger was stated as one of the driving factors responsible for sexual practice in the study and that is not very different from reasons given in some studies conducted elsewhere (Joshua et al., 2007; Joshua and Ogboi, 2009).

Lack of vocational training for the prisoners- The Nigerian Law Reform Commission in its study of several Nigerian prisons, observed that pragmatic measures are yet to be taken to enable the prisoninmates to acquire useful educational and professional skills to be gainfully employed on discharge. Training programmes for prison inmates are inadequate and disorganized. Invariably, prison inmates interested in acquiring professional skills while in prison, with the hope of setting up their own business on discharge, end up becoming frustrated and dejected due to inadequacies in training programmes finally resorted to become aggressive toward the prisoner (Iwoh, 2004).

Other challenges included lack of voting rights and access to conjugal facilities, lack of access to information and education, issue of new-borns staying with their mothers in prison,[14]lack of recreational facilities and lack of adequately motivated staff (Ajomo and Okagbua, 1991; WHO, 2001; Alemika and Chukwuma, 2001; Joshua, 2007).

HUMAN RIGHTS AND ETHICAL ISSUES IN NIGERIAN PRISONS

There are several international legal instruments- conventions, charters, principles that are relevant to human rights and ethical issues in prisons.

Human rights are guarantees for human beings to be able to achieve happiness and self-respect; and Human rights confirm that these rights do not stop at prison gates**.** These rights are coveredby**:** International covenant on civil and political rights (ICCPR),Standard minimum rules for the treatment of prisoners (SMR), Universal declaration of human rights (UDHR),Convention against torture and other cruel, inhuman or degrading treatment or punishment (CAT),Convention on the rights of the child (CRC). International covenant on economic, social and cultural rights (ICESCR), Principle of medical ethics, Tokyo rules, Principle of detention or imprisonment (PDI), Basic principles for the treatment of prisoners (BAT) among others (HRP, 2005).

No one shall be subjected to torture or to cruelty, inhuman or degrading treatment or punishment and everyone has the right to a standard of living adequate for health and well-being of himself and of his family, including food, clothing, housing and medical care (UDHR articles 5 & 25) (HRP, 2005).

All persons deprived of their liberty shall have the right to an adequate standard of living, including adequate food, drinking water, accommodation, clothing and beddings (UDHR article 25) and all deaths in custody and disappearances of prisoners shall be properly investigated (PDI principle 34)(HRP, 2005).

Accommodation for prisoners shall provide adequate cubic content of air, floor space, lighting, heating and ventilation (SMR rule 10) and prisoners required to share sleeping accommodation shall be carefully selected and supervised at night (SMR rule 9 (2). Adequate food and drinking water are human rights (ICESCR article 11) (HRP, 2005).

The enjoyment of the highest attainable standard of physical and mental health is a human right (ICESCR article 12) and it is a basic requirement that all prisoners should be given a medical examination and treatment (free of charge) as soon as they have been admitted to a prison or place of detention (PDI article 24; SMR rule 24) (HRP, 2005).

The primary responsibility of health care personnel is to protect the health of all prisoners (Principle of Medical Ethics, principle 1-6) and the main aim of the prison authorities in their treatment of prisoners should be to encourage personal reformation and social rehabilitation (ICCPR article 10 para 3) (HRP, 2005).

Vocational training shall be provided, especially for young prisoners (SMR rule 7 (5) and education and cultural activities shall be provided and encouraged, including access to an adequate library. Education in prisons should be aimed at developing the whole person, taking account of prisoners' social, economic and cultural background (BPT principle 6). Education shall be compulsory for young

prisoners and illiterates. The prison authorities should give this high priority (SMR rule 77) (HRP, 2005).

A prisoner's request to be held in a prison near his or her home shall be granted as far as possible (PDI, principle 20) and pregnant women and nursing mothers who are in prison shall be provided with special facilities which they need for their condition (SMR rule 23 (1) (HRP, 2005).

Anyone who is arrested has the right to trial within a reasonable time or to release (ICCPR article para 3; PDI principle 38). Persons awaiting trial shall not be detained in custody as a general rule (ICCPR article 9 para 3)(HRP, 2005).

Personal shall be appointed as full time prison officers, with civilian status, salaries adequate to attract and retain suitable men and women, and favourable employment benefits and conditions of service (SMR rule 46 (3) (HRP, 2005).

CONCLUSION

If Nigerian prisoners are human (which they are), then the time for prison reform is long overdue. Policy makers and implementers, prison authorities, Human Right Activists, Politician, NGOs, Public Health Experts, Faith Based Organisations, Journalists, Civil Liberty Organisations and other relevant stakeholders have very important roles to play in ensuring that these marginalized, forgotten and voiceless individuals are treated humanely while they are serving their prison sentence in order to achieve the basic aims of punishment.

Fixing of the numerous problems in the prisons is mainly the responsibility of the Nigerian government because agencies such are the judiciary and the court, the Nigeria police force, independent corrupt practices and other related offence commissions, Ministry of Interior among others are all agencies of government. The efficiency of all these agencies can be checkmated by the same government.

The way forward includes-

The decongestion of the prisons through speedy trial of inmates, release of sick, old, under aged and handicapped prisoners. Improvement of basic welfare needs of inmates and living conditions by the relevant stakeholders and the use of community service and house arrest for minor offenders. Provision of employment and microcredit schemes by the relevant government agencies for discharged skilled prisoners to start their own business after their prison sentence to reduce recidivism.

Increasing staff strength and regular training and re-retraining of staff by the Ministry of Internal Affairs to enhance their capacity and motivate them; Prisoners should be given greater access to vocational training and skill acquisition opportunities.

There is need for thorough medical assessment of people who have committed crime in order to identify those that are cases of psychiatric disorders so that they could be sent to an appropriate treatment centre instead of prison.

Finally, addressing factors that play role in crime such as poverty, injustice, unemployment, corruption and poor governance among others and provision of preventive medical services and conjugal facilities where appropriate.

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Ethics in Transfusion Medicine

Dr. Shamee Girish

Ethics is basically a set of moral values or a code of conduct. The practice of transfusion medicine involves a number of ethical issues as the source is from humans and is a precious resource with a limited shelf life. Therefore, it entails moral responsibility towards donors and patients. The ethics revolving around transfusion medicine is based on the four fundamental principles/pillars of clinical/ medical ethics: autonomy, beneficence, non-maleficence and justice[1.] It has been argued that the adoption of such principles effectively eliminates conflict. Clearly, achieving an improvement in a patient's condition and avoiding harm is the prime goal of all who practice medicine.

Autonomy is the acceptance of freely and fully informed decisions of an individual. Competent adults have the right to determine what will (and will not) be done with his or her own person. This right includes making decisions based on the patients' personal values which may differ from societal norms. Cultural and ethnic factors may also be considered.

For an informed consent for any transfusion, the clinician should

- Provide relevant information
- Avoid withholding information

The patient should be provided with the correct and current information about blood transfusion such as indication for transfusion, alternatives/ autologous/ bloodless alternatives, risks and benefits of the transfusion.

Consent for transfusion is based on the principle of autonomy. Consent must be informed; patient must understand the nature of the procedure, risks, and benefits of the treatment. It must be given voluntarily and is specific to both the treatment and the person providing it

Disclosing to the patients, in depth knowledge about the risks associated with transfusion is necessary and the doctor should know what to disclose and what not to reveal. Few of the risks are mainly theoretical and not always obvious. For example, the effects of transfusion related immune modulation need not be discussed with the patient. But it is imperative to inform about the acute and delayed transfusion reaction and the risk of transmission of infections due to blood transfusion. Risks should not be presented in isolation. The patient should be given the information in a context that includes a comparison with other risks, such as those of other aspects of the treatment plan, those of alternative treatments that do not require transfusion and those that require no treatment.
The corollary of the right to consent to transfusion is the right to refuse and this right applies even when the refusal will result in harm.[2]The ideal example is the refusal of transfusion by Jehovah's Witness for any blood or blood components. Their belief is based on the fact that "God, the Creator of life, views blood as sacred and holy, and therefore should not be used for the purpose of transfusion, regardless of the consequences".

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The references are several Bible passages, e.g.: Genesis 9:3–4; Leviticus 17:10 etc. The details of the components that are generally accepted by Jehovah's Witness is shown in Table 1

Table 1. Details of the acceptability of blood components among Jehovah's Witness

Not Acceptable	Acceptable	Matters of Conscience
Whole blood Autologous Red Cells Platelets Plasma	Crystalloids Synthetic colloids Recombinant products - Epo,coag. factors	Albumin Immunoglobulin vaccines Coag. Factors (non-recombinant) Intraoperative cell salvage

A few people reject transfusion of blood products due to secular reasons but ethically, it is necessary for the physician to respect the cultural practices of the patient while meeting legal and professional obligations.

Before consent is obtained for blood transfusion, the doctor must ensure that the patient is competent to consent. Competency is the ability to make a *reasoned* decision, i.e. the person must be able to comprehend the implications of the treatment and understand consent, or refusal.

Substitute consent

Substitute consent is given by one person on behalf of another, where patients are considered as incompetent to give consent. A few examples include: a child under the age of fourteen, people with mental illness, dementia, brain damage or intellectual disability, and those who are temporarily or permanently impaired by drugs or alcohol.

Surrogate decision makers should effectuate the patient's preference as stated prior to patient losing decision making capacity. The surrogate decision making should be based on the best information available, approximate what patient would have wanted which is called '*substitute interest'* standard. If no information is available, the decision is made in the best interest of the patients which is called '*best interest'* standard.

Transparency model

The primary goal of informed consent is 'transparency'. According to this standard, adequate informed consent is obtained when a reasonably informed patient is allowed to participate in the medical decision to the extent that patient wishes. In turn, "reasonably informed" consists of two features: (1) the physician discloses the basis on which the proposed treatment or alternative possible treatments have been chosen; and (2) the patient is allowed to ask questions suggested by the disclosure of the physician's reasoning, and those questions are answered to the patient's satisfaction. According to the transparency model, the key to reasonable disclosure is not adherence to existing standards of other practitioners, nor is it adherence to a list of risks that a hypothetical reasonable patient would want to know. Instead, disclosure is adequate when the physician's basic thinking has been rendered transparent to the patient. If the physician arrives at a recommended therapeutic or diagnostic intervention only after carefully examining a list of risks and benefits, then

rendering the physician's thinking transparent requires that those risks and benefits be detailed for the patient. If the physician's thinking has not followed that route but has reached its conclusion by other considerations, then what needs to be disclosed to the patient is accordingly different. Essentially, the transparency standard requires the physician to engage in the typical patient-management thought process, only to do it in a language understandable to the patient.

Physicians Liability

A physician can be liable for breaches of the principle of informed consent in 3 ways: by failing to seek consent, by failing to disclose properly the information required for the consent to be considered "informed", including the risks and benefits of transfusion and the available alternatives and the risks and benefits of the alternatives and by providing treatment in the face of an express refusal. When such due diligence is exercised by the physician and hospital, there is little, if any, need to be concerned about litigation arising from a patient whose refusal of blood leads to morbidity or mortality.

Beneficence versus Autonomy

Beneficence is the 'Commitment to do good things'. The term beneficence refers to actions that promote the well-being of others. In the medical context, this means taking actions that serve the best interests of patients. However, occasionally there can be conflict between the principles of autonomy with the principles of beneficence (Example: Case 1 given below).

Case 1. A 22 year old Mr. X came with true altruism for blood donation. On donor interview, he gave a history of convulsions and loss of consciousness during previous blood donation and fainting during blood sample collection. In view of previous serious donor reaction he was deferred and doctor advised him not to donate blood in future.

Medical paternalism

From time immemorial, 'first do no harm' is one of the main principles of medical practice. In the above case donor is deferred by the medical officer to prevent donor reaction. Many such donors who get deferred due to various reasons may get disappointed which may in turn affect the return rate.[3] But the physician acts from a benevolent spirit in providing beneficent treatment that in the physician's opinion is in the best interests of the donor/patient, without consulting the donor/patient, or by overriding the donor/patient's wishes, it is considered to be "paternalistic." Here, the duty of beneficence requires that the physician intervene on behalf of saving the patient's life or placing the patient in a protective environment, in the belief that the patient is compromised and cannot act in his own best interest at the moment. Medical paternalism is justified when the patient is at risk of serious preventable harm, and the paternalistic action will prevent the harm or projected benefits of the action outweigh the risks to the patient. In such cases, the least autonomy restrictive alternative should be adopted.

Non-maleficence

Non-maleficence means to "do no harm." Physicians must refrain from providing ineffective treatments or acting with malice toward patients. This principle, however, offers little useful guidance to physicians since many beneficial therapies also have serious risks. The pertinent ethical issue is whether the benefits outweigh the burdens. Physicians should not provide ineffective

treatments to patients as these offer risk with no possibility of benefit and thus have a chance of harming patients. In addition, physicians must not do anything that would purposely harm patients without the action being balanced by proportional benefit. Where this principle is most helpful is when it is balanced against beneficence. In this context non-maleficence posits that the risks of treatment (harm) must be understood in light of the potential benefits. This principle constitutes the ethical fabric of legal determination. Non-maleficence reminds you that the primary concern when carrying out a task is to do no harm. Beneficence promotes action that will support others. These two theories taken together state that you must act in a manner that cultivates benefit for another and at the same time protects that person from harm.

Justice

Justice is a complex ethical principle, with meanings that range from the fair treatment of individuals to the equitable allocation of healthcare and resources. It is concerned with the equitable distribution of benefits and burdens to individuals in social institutions, and how the rights of various individuals are realized. As per this principle, there should be no discrimination on the basis of social status, race, religion or community. All people should be treated fairly and equally irrespective of their respective backgrounds. Blood is a public resource and access should not be restricted[4]. Justice is a concept intended to promote fair and equitable treatment of individuals within populations. Ostensibly, it seems like a very straightforward and simple principle of ethics. However, applying *Justice* within populations in clinical settings is often challenging and requires constant vigilance to ensure that its intentions are upheld.

To promote the health and safety of blood donors and recipients of blood and blood products, WHO was joined by the International Society of Blood Transfusion (ISBT), the then League of Red Cross and Red Crescent Societies (LRCRCS), and other donor agencies. In 1980, ISBT endorsed its first formal Code of Ethics. A Revised code of ethics was published in 2000

ISBT Code of Ethics for Blood Donation and Transfusion[4]

1. Blood donation including haematopoietic tissues for transplantation shall, in all circumstances, be voluntary and non-remunerated; no coercion should be brought to bear upon the donor. The donor should provide informed consent to the donation of blood or blood components and to the subsequent (legitimate) use of the blood by the transfusion service.
2. Patients should be informed of the known risks and benefits of blood transfusion and/or alternative therapies and have the right to accept or refuse the procedure. Any valid advance directive should be respected.
3. In the event that the patient is unable to give prior informed consent, the basis for treatment by transfusion must be in the best interests of the patient.
4. A profit motive should not be the basis for the establishment and running of a blood service.
5. The donor should be advised of the risks connected with the procedure; the donor's health and safety must be protected. Any procedures relating to the administration to a donor of any substance for increasing the concentration of specific blood components should be in compliance with internationally accepted standards.
6. Anonymity between donor and recipient must be ensured except in special situations and the confidentiality of donor information assured.

7. The donor should understand the risks to others of donating infected blood and his or her ethical responsibility to the recipient.
8. Blood donation must be based on regularly reviewed medical selection criteria and not entail discrimination of any kind, including gender, race, nationality or religion. Neither donor nor potential recipient has the right to require that any such discrimination be practiced.
9. Blood must be collected under the overall responsibility of a suitably qualified, registered medical practitioner.
10. All matters related to whole blood donation and haemapheresis should be in compliance with appropriately defined and internationally accepted standards.
11. Donors and recipients should be informed if they have been harmed.
12. Transfusion therapy must be given under the overall responsibility of a registered medical practitioner.
13. Genuine clinical need should be the only basis for transfusion therapy.
14. There should be no financial incentive to prescribe a blood transfusion.
15. Blood is a public resource and access should not be restricted.
16. As far as possible the patient should receive only those particular components (cells, plasma, or plasma derivatives) that are clinically appropriate and afford optimal safety.
17. Wastage should be avoided in order to safeguard the interests of all potential recipients and the donor.
18. Blood transfusion practices established by national or international health bodies and other agencies competent and authorized to do so should be in compliance with this code of ethics.

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The implementation of the institute of Compensation of moral damage to the Armenia legislation

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Abstract: The Armenian civil code was not stipulated the institute of compensation for moral damages although Armenian Constitution declared a human dignity as the one of the highest values. After many claims asking the compensation of moral damage, the Constitutional Court of the Republic Armenia put an end to the issue deciding that the gap in the legislation blocks the efficient realization of the rights of just trials. The Armenian parliament adopted the amendment to the Civil Code establishing a compensation for non-pecuniary damages only in cases where the state had violated the rights guaranteed by the European Convention on Human Rights. In other cases, the issue of compensation for non-pecuniary damage remains unresolved.

Key words: moral damage, compensation, human dignity, legal entities, legal liability, civil code.

After the collapse of the Soviet Union, in 1995, Armenian constitution was worked out and adopted. It helped to pass from socialism to capitalism providing the development of the country based on the general liberal principles of law.

The Universal Declaration on Bioethics and Human Rights provides (Article 3) the legal rule on fully respecting of human dignity. This rule is reflected in the third article of Armenian Constitution. According to the Article 3 of the Constitution, a human being, her/his dignity and the fundamental human rights and freedoms are an ultimate value; the state shall ensure the protection of fundamental human and civil rights in conformity with the principles and norms of international law; the state shall be limited by fundamental human and civil rights as a directly applicable law. One of the valuable rights presented in the constitution is the right to dignity. Thus the Constitution of Armenia declared a human dignity as the one of the highest values and principles that must be respected and protected by the state.[1]

The post-soviet Civil Code of Armenia (enforced from the January of 1999) provided only for two types of damages: actual damages and lost benefits. Thus, the compensation for moral damages was not planned to be in the civil code. However, it was planned to be introduced for the foreign investors according to the Article 9 of the Armenian law 'On the foreign investments' (1994), and according to the Article 23 of the Armenian law 'On the advertisement' (1995). The latter, was to protect those physical and legal entities, whose rights had been violated as a result of a dishonest advertisement. Nonetheless, these provisions had never been enforced, and had not provided the appropriate protection of the person's dignity.

Although the gap in the regulation of the relations related to moral damages created ambiguity, it did not hinder people to file actions for compensation for moral damages at courts. Among a number of cases the most notable was the action of the Kocharyans family against the

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Newspaper 'Armenian Times', their demand was to deny the printed misinformation about him and compensate his moral damages (five million AMD), as well as the attorney fees (approximately three million AMD). As a result of a gap in the legislation, the demand to compensate for moral damages was fully rejected, but the demand of the denial and payment of the attorney fees were granted, without preserving the letter of the law according to which the attorney fees are to be granted in case the claim for relief is granted. The press labelled this kind of lawsuit as a political order and persecution, and the possible statement about the moral damage was labelled as a means of restriction on the freedom of press. After this the Russian-Armenian (Slavonic) University, as a legal entity, filed a complaint against another mass media – 'Liberalism', demanding to compensate for moral damages and for attorney fees.[2] In this case the compensation of moral damages was rejected as well, only forcing to deny the information spread via press and pay the fees of the plaintiff's advocate. According to the constitution of Armenia, the main rights and freedoms of a person refer also to the legal entities to the extent those rights and freedoms in their nature are applicable to them. But for the legal entities the sectoral regulations are different. According to the Penal Code of the RA, legal entities are not subject to responsibility. In this case the parliament of the RA follows the doctrinal category adopted in the German legislation, according to which only a physical entity has will and consequently sin. The sin (it can be in the form of intention or negligence) is a necessary condition to hold a person liable. In the legislation on administrative responsibility there is no conceptual solution referring to this issue. In some cases, it is not subject to responsibility, and in some cases, for example, in case of violations in tax field even the branches of the banks are recognized as self-dependent entities for responsibility purposes. By the way, before adopting the Civil Code in 1999, the legislation of the RA was deciding on the institution of the compensation of the moral damage, moreover, even for the legal entity. But those legal norms were left unaccomplished. The aim of some of these and more than ten other plaintiffs was to get to the Constitutional Court and have the gap in the law recognized as anti-constitutional.

In the decision of European Court of Human Rights (hereinafter ECtHR) Meltex LTD and Mesrop Movsesyan v. Armenia[3], the court had provided the organization with the compensation of the moral damage for the rights guaranteed by convention of the state, became a stimulus for bringing such new cases into the court. In another case Virabian v. Armenia, the ECtHR made a statement about the necessity of the compensation of moral damages, highlighting the idea that the state violates the Article 13 of the European Convention of Human Rights (the right for an effective remedy) by not providing the compensation for moral damages.[4] As a result of the flow of complaints to the courts to compensate for moral damages, in 2010 some amendments were adopted in the Civil Code. According to the Section 1087.1 of the Code, an opportunity was given to demand a public act of begging pardon and compensation of 1-2 million AMD for abuse and defamation. Although they were not defined as compensation for moral damages, it was obvious that the compensation for the damages to one's honour, dignity or business reputation was itself meant to compensate for

moral damages. Additionally, the ECtHR in two others decisions against Armenia underlines the gap of compensation for moral damages in Armenian legislation.

In the case Poghosyan and Baghdasaryan against Armenia, the accused was wrongly sentenced for murder and he had spent about 5 years in prison. In May 2004, Mr. Poghosyan was recognized as avictim, having suffered moral damage as a result of the unlawful actions of the investigating authority. On 28 April 2005, the courts dismissed this claim on the ground that this type of damage was not envisaged by the Civil Code. The ECtHR have noted that the applicant had not been able to apply for non-pecuniary damage under Armenian law and there had therefore been a violation of Article 13.

In the case Khachatryan and others v. Armenia the applicants are Jehovah's Witnesses. Having applied to the authorities to perform alternative labour service instead of military service on religious grounds under the 2004 Alternative Service Act, they were each assigned to perform the service in various institutions such as hospitals, nursing homes and dispensaries. In May and June 2005, they respectively informed those institutions that, since the alternative service was under the control of the military, they could not continue to serve in good conscience, and subsequently left their places of service. Placed in detention for several months following criminal proceedings brought against them for abandoning their service institutions, the applicants complained that they had been detained for an act which had not constituted an offence at the time, in breach of Article 5 § 1 (right to liberty and security) of the ECHR. Further relying in particular on § 5 of Article 5 (right to compensation for unlawful detention) they complained that they had been denied compensation for their unlawful detention.[5]

The Constitutional Court of the Armenia put an end to the issue of the compensation for moral damages based on Khachatrian’s application, on the occasion of deciding on the correspondence between the Civil code and the Constitution of the RA (Dec. No. 1121, 05.11.2013). According to the Court, such a gap in the legislation blocks the efficient realization of the rights of just trials, and at the same time hinders the conscientious realization of the international duties of the RA.[6]

After all this court decisions in 19.05.2014 the Armenian parliament adopted the amendment to the Civil Code, by which the legislature established a compensation for non-pecuniary damages only in cases which are provided by the Civil code. The compensation for Non-pecuniary damages is provided only in cases where the state had violated the rights guaranteed by the ECHR. In other cases, the issue of compensation for non-pecuniary damage remains unresolved.

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Sowing the ethical seeds early

Initiating the Student Wing of the Bioethics Unit at Kasturba Medical College, Manipal

In the MBBS course, we are taught bundles and bundles of theory. Medicine, Surgery, Pathology etc. At the end, we will turn out to be subject experts with strong theoretical competencies. But how often are we taught how to approach a patient? How to talk to their family members regarding the matter at hand? When are we taught to treat the patient as more than just a case file?

Until our 4th semester, we were quite unaware regarding the concept of Bioethics. The knowledge we had so far came just from our Forensic Medicine lectures on Medical Ethics. The Student Research Forum workshop on Bioethics was a required eye opener for us. It taught us the importance of learning a certain amount of etiquette, and also to abide by a code, and to carry out ethical practice.

In order to provide medical care in a humane way, we need to be *better* educated about specific aspects of ethical medical practice and learn to think critically about the increasingly complex world of medicine. Knowledge and experience of the humanities is a key element of caring for patients as persons. This has led to need of medical humanities in some teaching centres. For example, when physicians read poetry or fiction that explores aspects of human illness and suffering, it provides them with exposure to the human experience of health care that may become lost in the daily activities of technological medicine.

It is necessary to start early, i.e. during MBBS, since the habit of ethical practice needs to be inculcated in the students, before it is too late. As they say, whatever we learn early stays with us for a long, long time. Having a Bioethics Student Wing will give students the opportunity to build important skills regarding honorable and respectable practice.

So, this is what we propose to start in our college: We start off with 20-30 students. They get divided into groups, with 5-6 members. We plan to conduct weekly sessions of one hour each Session 1- There will be a 15 minute introduction, followed by a discussion regarding a well-known case, involving major ethical issues and the action taken in that particular case. One of the groups is selected to search and find and present a case the next week. Session 2 and beyond- The case discussed in the previous session would be open to 15 minutes of discussion on what were the other options available. The next 45 minutes are spent in the presentation by one of the groups.

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These presentations could be on one of the following

1. Famous cases of ethical conduct/ misconduct and how they were sorted out

2. Personal experience shared by a family member or relative at a clinic, as a patient

3. Financial constraints of families and the options available and decision making

4. How should the news (and consequences) of certain conditions and/or procedures be informed, and to whom

5. Any other ethical issue that a student feels the need to address

The 15 minutes discussion of the previous session is basically to view different perspectives of how that particular case could have been handled better. This, according to us would make students inculcate and practice these habits when they start their careers as doctors. This is about what has happened in the past. New cases spring up each day. A WhatsApp group with the members will be formed, which would be open to discussions of new cases coming up. Fund Collection strategies for those in need can also be planned and discussed. This endeavour would simply be to create awareness of how small actions and efforts in the right direction could lead to big changes.

Our main focus rests on forming a student organization to find out ways of improving our own conduct and that of our fellow budding doctors. This can ensure that even in this busy world where the main priority is making money, the essence of the doctor being a "healer" is not lost and better doctor patient relationships emerge, resulting in a happier and more satisfied patient walking out of our clinics.